

NEUROSIS AND SOCIAL CLASS

I: SOCIAL INTERACTION^{1, 2}LAWRENCE Z. FREEDMAN, M.D., AND AUGUST B. HOLLINGSHEAD, PH.D.^{3, 4}
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INTRODUCTION

This report is intended as a contribution toward understanding the complex and diverse interaction patterns which are summated in the diagnosis of neurosis. The term neurosis describes a condition of subjective malaise and disturbed social interaction according to criteria accepted by one or more participants in the labelling process. It arises from a juncture of the experience of the patient, the training and techniques of the doctor, and the social patterns and values of their communities. One of the hypotheses we may derive from this observation is that certain psychological symptoms and interpersonal manifestations which are considered pathognomonic of neurosis may be intimately linked with the social class position and social role of the sufferer.

Epidemiological research in mental illness has recently been concerned with the patterning of psychological problems in the various social levels which make up the modern community. Among others, the Yale group, headed by Redlich and Hollingshead (1), has been studying and reporting its findings on the interdependence of social structure and psychiatric disorders. This paper reports one facet of that extensive investigation.

Other inquiries have also shown that neurotic groups from varying socio-economic backgrounds fall into different diagnostic categories. Freedman and Leavy (2) reported differences in the incidence of particular psy-

chiatric syndromes between upper- and lower-class neurotics. They found, for example, that somatization reaction, anxiety, conversion hysteria, and character disorder were much more frequently diagnosed among lower-class patients and that depressive reactions are more commonly diagnosed among the upper social classes. They also discussed the relationship of economic factors to the development and precipitation of neurosis in patients in an urban private and clinical practice (3). We have described significant differences in referral mechanisms and treatment practices which are related to the class position of psychiatric patients (4).

Our data are derived from a psychiatric census of patients in private and public facilities in a New England university city of 250,000 population in 1950. In the statements to follow, both factual and theoretical, we refer *only* to the *treated* prevalence of neurosis, *not* the probable endemic prevalence in the community.

Since a number of papers from this ongoing research project have already specified the method, we shall describe it briefly and refer you to these other publications (1).

In addition to determining those who were receiving psychiatric care, a 5% systematic sample of the community's population was selected and both the general population and the psychiatric populations were stratified into 5 classes using Hollingshead's "Index of Social Position" (1). This index is based upon the criteria of education, occupation, and residence. The principal social levels have also been fully presented in our earlier reports. They range from the top socio-economic position, Class I, to Class V, the lowest.

GENERAL RESULTS

There were 1,963 psychiatric patients in the community of whom 449, or 23.5%, were diagnosed as neurotic. The rates of

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⁴ We wish to thank Mrs. Hans Hoffman for her valuable assistance in the statistical analysis of our data.

This One



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TABLE 1
RATES OF NEUROTIC PATIENTS IN TREATMENT PER
100,000 POPULATION IN THE NEW HAVEN
COMMUNITY, BY SOCIAL CLASS

Social class	Neurosis
I and II	364.2
III	237.4
IV	146.5
V	163.2

treated neurosis per 100,000 of population are presented in Table 1. These rates which have been standardized on the age and sex of the community's general population are significantly different from one class to another.

From these rates we can conclude that the prevalence of neurosis which has been diagnosed or treated by a psychiatrist is *positively* related to social class position. The higher the social position, the greater the rate of neurotics in treatment.

Having determined this important social class difference, who are the people and what are the agencies responsible for bringing these neurotic individuals into a psychiatric setting? Table 2 shows that the neurotics in the 5 classes are referred to psychiatrists in quite different ways. These variations are, in fact, greater than can be expressed in graphic form.

One of 3 neurotics in the top 2 social classes came to the psychiatrist through his own initiative or that of a friend or family member, without any outside agency or professional direction. About 1 of 10 in Class V was brought into contact with psychiatry in this personal and voluntary way.

Medical sources referred 61% of patients in Classes I and II, and 36% in Class V. This

TABLE 2
PERCENTAGE OF NEUROTIC PATIENTS, BY TYPE OF
REFERRAL AND CLASS

	Class			
	I and II	III	IV	V
Self, family, friends.	33.7	29.6	23.5	11.5
Medical	61.2	56.5	57.7	36.0
Other professionals.	4.1	7.8	9.1	29.5
Legal (police and courts	1.0	6.1	9.7	23.0
n —	98	115	175	61
$X^2 = 61.2184$ $p = .001$				

in itself is a striking difference. Perhaps more important, however, is the fact that almost all the upper-class patients were referred by their private physicians (to privately practicing psychiatrists), while 90% of those in Class V were referred from the outpatient clinics of a general hospital (to public or clinic psychiatric facilities).

Other professions refer fewer than 1 of 20 Classes I and II neurotics to psychiatrists, while about 1 of every 4 Class V neurotics come to the psychiatrist in this way. Ministers and attorneys refer most of the small remaining number of upper-class patients, teachers in Class III, and social, welfare, and legal agencies in Classes IV and V.

About 1 of every 4 neurotic individuals in Class V who are seen by a psychiatrist arrives through the intervention of a legal agency—either the police or the courts. They cannot generally be considered to be "voluntary" patients. Legal referrals occur with only 1 in a 100 upper-class neurotics.

Classes III and IV occupy intermediary positions with regard to this referral mechanism, as the table shows.

These observations demonstrate that the prevalence of treated neuroses is related to the social level and that the referral methods are linked to the social role.

These class biases in referral mechanisms were matched by striking differences in the psychiatric treatment these patients subsequently received(4). Most upper-class patients were treated by private practitioners, and most lower-class patients in public clinics or hospitals. But in both public and private facilities the higher the class position, the greater was the likelihood that the patient would be treated individually and intensively over a longer period with psychological methods. The lower the class position, the greater likelihood that he would be treated by organic methods, seen with less frequency, and less intensity, and for a shorter time. These distinctions were exemplified in psychoanalysis which was practiced exclusively with the upper 2 classes and never in the lower class.

What about the neurosis itself? The remaining portion of this paper concerns itself with such preliminary observations concerning the symptom pattern and social interaction of the neuroses in the various classes.

OPERATIONAL CONCEPTS

Psychiatric diagnosis of neurosis is not yet standardized; there is variation in the nomenclature and the meaning ascribed to the diagnostic categories. There is widely differing emphasis on phenomenology, and etiology. This lack of uniformity makes comparison of diagnostic categories difficult. We, therefore, divided the *phenomena* of the patients' behavior and feelings into 2 groups: First, groupings of psychological symptoms of the patients, and second, their social behavior. Our data represent a slice of an interaction process including the complaints of the patient and the perspective of the physician.

In this report we concentrate on our studies into the social interaction processes and simply state that we were able to derive class profiles of distinctive configurations of patterns of psychological symptoms(5).

All evidences of intra- and interpersonal interactional processes were arranged into a series of 6 categories according to extensity and severity of overt social difficulty. The 2 first groups may be properly referred to as intrapersonal symptomatology, but were included to complete the spectrum. Its 2 major divisions are (A) the subjective malaise, the inner perception and response to distress or lack of ease; this covert category of the social interaction group is inclusive of anxiety, depression, and the general category of defense symptoms, and the second (B) subsumes all other symptoms which are predominantly related to somatic elements; these include actual somatic malfunction or psychopathological inner perception of bodily malaise or malfunction.

The overt interpersonal manifestations were divided into 4 categories according to their area of operation. The primary or inner group (C) is that of the nuclear family, including both the family of origin and family of procreation. The second (D) social grouping is that of the larger social community with which the patient interacts; this includes the peer group of the individual. The next group (E) represents his more structured interaction with the larger group, his vocational relationships, or, in the case of children, school. Finally, the most formal unit, and in a sense, the severest, within his social milieu is the legal structure (F).

This gives a calibrated scale going from the subtlest inner self-discontent to the most severe formalized forms of social interaction. All combinations of such interaction are, of course, possible, and we therefore devised an arithmetical system whereby this could be expressed, again in a graduated series. The lowest number represents the most covert neurotic difficulties, socially speaking, and the largest, the most overt. This gave a numerical symbol of the extensity and intensity of social interaction in each case.⁴

The Social Interaction Index is the arithmetic mean of the numerical equivalents of the extent or degree of social involvement. The lowest possible score is 1, the highest, 63. Every intermediate number may occur—indicating a progression of expanding areas of involvement, from subjective "outward" to legal.

SOCIAL INTERACTION

Table 3 shows the percentage in each class in this scale in which subjective malaise or somatic difficulties existed to the exclusion of overt social difficulties. The case records or physicians' reports did not mention social difficulties or, if they alluded to them, they were minimized or subordinated to these symptoms.

Subjective malaise alone is more than twice as high in Classes I and II as in Classes IV and V. Class III in this as in other categories holds an intermediate position not only in its sociologically defined characteristics but also in social manifestations of the neurotic process.

Somatic symptoms alone showed a far lower percentage in Classes I and II, 4% compared with 30% in Class III and 59% in Classes IV and V.

Thus there are consistent differences at each interaction level, but class differences widen as we progress into larger orbits.

Ninety-six percent of Classes I and II

⁴ The ratings were made by the psychiatric author, using no information except the symptoms themselves. They were tested for reliability against the ratings of a nonmedical researcher working from a comprehensive, descriptive protocol. Reliability was found to be high initially and with greater experience both raters were essentially identical in their results.

TABLE 3
SOCIAL INTERACTION

A. Percentage of subjective and somatic symptoms alone— by class				
Per cent by class				
	I and II	III	IV and V	
Subjective	88.0	56.0	32.0	
Somatic	4.0	30.0	59.0	
n —	23	14	21	
B. Percentage of total cases showing levels of social interaction				
Per cent by class				
	I and II	III	IV	V
Subjective	96.0	90.4	85.1	83.6
Somatic	48.0	59.1	76.0	63.9
Family	25.5	34.7	33.7	42.6
Peer group or community	31.6	24.3	26.9	45.9
Occupation	16.3	27.8	24.6	37.7
Legal	5.1	0.9	8.6	19.7
n —	98	115	175	61
Per cent—percentage of total number of cases in each class with the particular social interaction				

show subjective symptoms, compared with 84% in Class V. Forty-eight percent in the top class had somatic complaints, compared with 64% in Class V.

We now turn to the overt aspect of this total interaction pattern. Twenty-six percent of cases in Classes I and II show family interaction difficulties compared with 43% in Class V. More important, family difficulties in Classes I and II differ markedly from those in Class V in "quality." While the social unit is the same, the degree of overtness, and even aggressiveness, increases as we go down the scale. There is a 32% involvement in peer group or community difficulties in Classes I and II compared with 46% in Class V. Classes III and IV ranged around 25%. The more serious legal ruptures rose from 5% in Classes I and II to 20% in Class V.

Analyzing every case by social system complex and by class, we found the same thing, with these additional patterns: Classes I and II have more subjective symptoms alone and subjective symptoms in combination with community problems than would be expected. Class III has more cases in which subjective, somatic, and family were combined. It has fewer cases than would be expected with

legal problems in any combination. Both Classes IV and V have fewer subjective symptoms, and Class V has far more complexes in which all categories through the community and vocational and legal problems are present.⁵

Every analysis, therefore, to which we have thus far subjected our data, gives us essentially the same results. Viewed in the perspective of their "social significance," manifestations of these neuroses range through a remarkably regular progression from introversive, intimate, personal symptoms in Classes I and II to the increasingly wider community crises and more severe social and legal collisions in the lower Classes IV and V.

CORRELATION OF PSYCHOLOGICAL SYMPTOMS AND SOCIAL INTERACTION INDEX

Sole psychological symptoms were correlated with the social interaction processes in the same patient.

The gradient is generally toward increased social difficulties in lower-class groups. Anxiety as a sole symptom is correlated with a score of 1 in Classes I and II, and with 11 in Class V. Somatic increases from 2 in Classes

TABLE 4
PSYCHOLOGICAL SYMPTOMS CORRELATED WITH
SOCIAL INTERACTION INDEX

A. Appearing as the sole symptom				
Class				
	I and II	III	IV	V*
Anxiety	1	3		11
Depression	—	9		43
Somatic	2	5		13
Behavior	20	16		42
Character	5	10		29
Other	4	9		7
B. Appearing with other psychological symptoms				
Class				
No. of symptoms	I and II	III	IV	V
2	10	11	12	17
3	10	9	17	18
4, 5, and 6	15	14	21	22
All cases with more than one psychological symptom ..	11	11	15	19

* Class V had no cases of depressive symptoms alone.

$$^5 X^2 = 108.18 \quad df = 13 \times 3 = 39 \quad p = .01.$$

I and II to 13 in Classes IV and V, behavior from 20 to 42, character from 5 to 15.

The lower part of Table 4 correlates the Social Interaction Index with 2 and more symptoms with more consistent results.

We also studied the social index of all cases in which the diagnosis involved a total personality response, called here character disorder, rather than a sole symptom or single dominant reaction pattern.

In the group made up of youngsters under 17 years of age, the average index of social involvement was 7.3 in Classes I and II increasing to 39.1 in Class V. These are largely boys under 17 who were referred to a clinic by juvenile authorities for behavioral difficulties in school or in the community. In the late adolescent and early adult group, this differential continues in the same direction. However, in the 25-39-year-old group, the social indices show the same trend to a somewhat lesser extent. It may be pertinent to note that in an on-going prison study by the Yale Study Unit in Psychiatry and Law (6), this age group has the largest representation in Classes IV and V. It is highly probable, therefore, that the individuals who would otherwise be in this group are now in jail. By adding all age levels, we get the following total social interaction index. There is a steady gradient from 10.1 in Classes I and II to 24.4 in Class V. The numerical equivalent of social malfunction in treated character disorder is more than twice as great in Class V as in the 2 classes highest in the social scale.

SUMMARY

We advance the hypothesis that the diagnosis of neurosis is the resultant of an interaction process involving the patient, the doctor, and the social group. A psychiatric cen-

sus shows that the prevalence of neurosis is positively correlated with social level and that there are important differences in method of referral of neurotics from the various social classes. By use of a psychological symptom scale, we describe a class configuration, ranging from subjective, introversive symptoms in the top classes to somatic complaints and behavioral difficulties in the lower classes. A social interaction index reveals that the locus of conflict progressed through increasingly wider areas of social dislocation—ranging from intrapersonal symptoms in Classes I and II to severe social and legal collisions in lower Classes IV and V. Correlation of all psychological symptoms and social interaction shows this consistent increase in social difficulties. The correlation of character disorder and social interaction illustrate these relationships in a striking manner.

Several operations now in process add to their significance: (a) Professional orientation of the psychiatrist, whether analytic, analytically oriented, or eclectic, is positively correlated with class; (b) patterns of symptoms are positively correlated with class; (c) symptom pattern and social interaction index are also being correlated.

From these findings, and from complementary results of the over-all investigation, we adduce that treated neurosis is a process within a social context which can be best understood by systematic observation not alone of the individual but of his interpersonal gestalt. Certain distinguishing characteristics of the social classes are reflected in the neurosis itself.

DISCUSSION

Our data show how varied are the community reactions and the psychiatric response to neurosis. Persons hauled in by the police for antisocial behavior or complaining of bodily aches, and treated by medication are neurotics. Others who seek psychiatric help stimulated by an inner sense of malaise and treated by infinitely subtle and prolonged verbal communication are also neurotics. When we discover that certain psychiatrists consistently describe a characteristic symptom complex and treat with equal uniformity of method, and that other psychiatrists persistently describe other symptoms and at-

TABLE 5
SOCIAL INTERACTION INDEX BY AGE AND CLASS
(Character Disorder)

	Age groups				Total
	-17	17-24	25-39	40 +	
Class I and II	7.3	11.4	10.9	7.7	10.1
Class III	22.0	15.0	9.9	13.4	13.3
Class IV	26.5	21.0	19.6	19.6	20.7
Class V	39.1	20.8	16.6	19.4	24.4

tempt to cure them with quite different techniques, and when, finally, we ascertain that their patients fall into definable groups bearing common social and behavioral characteristics—then similarity to medical disease processes as we traditionally conceive them is not great.

It is important, however, to distinguish between the possible *existence* of psychological and psychopathological states and the process of *diagnosis* of neurosis within a social context. Neither our data nor our inclination leads us to question the assumption that comparable unconscious mechanisms are common to all classes. Nor do we doubt that psychogenetic developmental elements such as identification, oedipal conflicts, and sibling rivalry, and psychosexual developmental patterns, are basic to all people in all classes. Certainly that nebulous phenomenon designated by the term "anxiety" is shared by all classes of neurotics. It is probably true, moreover, that anxiety is ubiquitous in the nonpsychiatric population. At present we would not even be justified in assuming that the difference is quantitative. Nor are we prepared to question seriously the possibility that there would be different results if analysts examined our Class V patients and eclectic psychiatrists treated our Class I subjects. But the point is *that they do not*. Treated neurosis is a conceptual abstraction of particular elements of behavior and feeling, and those who apply the concepts define the neurosis(7).

This paper offers some evidence concerning the role of the various participants in this process of definition. We have some hints concerning the role of the social group in making it. We have definite information concerning the part played by those who are professionally concerned. But it seems likely that a most important role in diagnosing "neurosis" is played by the individual who bears this label. Just how and why he accepts this designation is a fascinating and fundamental problem.

We have seen how agencies concerned with public order and morality, the courts and police, sometimes serve as transmitters of social deviants to the psychiatrist. Thus, the problem of conformity or nonconformity is shifted in a particular subculture from an

ethical question to a psychological problem. In a similar way ministers by their referrals conceptually alter a problem from one of sinfulness to one of neurosis and doctors in a like manner from physical pain to psychological conflict.

The criteria for assumption of the neurotic role differs significantly from class to class. It is quite likely that these group attitudes vary in turn and are undoubtedly affected by cross-class acculturation. From our data there is an apparent difference in concept of self as patient in the social classes if one is (1) uncomfortable or unhappy, (2) if his body hurts or functions poorly, (3) if he is unable to be effective at his work, (4) if he is in trouble with his social community, or (5) if he is in difficulty with the law.

We may indulge ourselves in the following (over) generalizations: The Class V neurotic behaves badly, the Class IV neurotic aches physically, the Class III patient defends fearfully, and the patients in Classes I and II are dissatisfied with themselves. Thus we have a motor pattern of community dislocation, a "body language" of pain and malfunction, social anxiety, and verbal symbolic dislocation, all called neurotics.

Stated another way, the Class V neurotic is often hailed before the psychiatrist because he is externally maladjusted (acts out, alloplastic) and the Class I and Class II patient most frequently comes because he is internally maladjusted (acts in, autoplatic).

Thus, there seem to be interesting and possibly significant class-typed neuroses, some characteristics of which may be principally due to the manner of referral and others to the sociological characteristics of the class. It is serious conceptual error to think of neuroses of certain types as being "correlated" with class position as though they were phenomena superimposed on a "class." We think of class simply as a system for conceptually dividing society into groups ranked together by the possession of common characteristics. The constant reiteration of the term in this paper may appear to give it a rigidity or a concreteness which goes beyond the intention of the authors.

The differences we have reported may equally be a function of the selective perception and focus of the interest of the

therapist. Raines and Rohmer(8) have shown how important the psychological refraction of the individual therapist is. They refer to the projective elements in diagnosis, and describe how the social background, technical training, and personal proclivities of the doctor affect his emphasis. In our data, we found that a psychiatrist tends to diagnose and treat according to his professional orientation or ideology. It is quite possible that a psychoanalyst would not report a complaint of abdominal pain in favor of sexual anxiety; while an eclectically oriented therapist might emphasize the former.

In a sense the doctor-patient relationship is a symbiotic one. Who chooses whom is not an easy question to answer. Each party to the therapeutic transaction requires the presence, at least the agreement, in all probability, of the other in order to carry out the procedures—if not to their mutual satisfaction—at least to allow them sufficient contiguity, comfort, and sense of “rightness” to proceed. In short, the same frame of reference must obtain between the two, or one must indoctrinate the other.

What implications do these findings have for our clinical practices? Psychiatric treatment as a psychological technique involves verbal communication requiring not simply physical presence but a state of receptivity, of motivation. Many lower-class patients tend to come into psychiatric milieu through official or semiofficial channels—channels in which the element of force is at least implicit. Ultimately, the individual must accept or at least acquiesce to the medical and social value systems which define his condition as neurotic and, hence, himself a proper subject for psychiatric attention. He must not only acquiesce but actually incorporate these values, if the method utilized is to be psychotherapy, since this employs relationships based on verbal communication, and an essential prerequisite is that there exist a shared intention to change something, whether it be the patient's ideas, emotions, or behavior. Many Class IV and Class V patients have nonverbal symptoms—their neurosis speaks a

kind of body or motor language. Their bodies hurt, or their behavior offends. The judgment that this is a psychiatric illness is often not theirs but that of official or semiofficial agencies.

It is at least a possibility that contemporary psychiatrists have learned to treat upper-class feelings through the manipulation of verbal cues and attempt to cure the Class IV and Class V bodily and behavioral symptoms in the same way. Perhaps it makes a pragmatic sort of sense that the behavioral and social maladaptations *are* treated by non-verbal behavioral manipulations, and more covert “feeling” neuroses are treated with attempts at manipulation of the complex, private verbal symbol. It might make better sense to recognize the often radically differing personal *and* social significance of the neurosis in different individuals and to develop relevant techniques—perhaps involving behavioral, social, and bodily symbols—more specifically than is now the case.

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